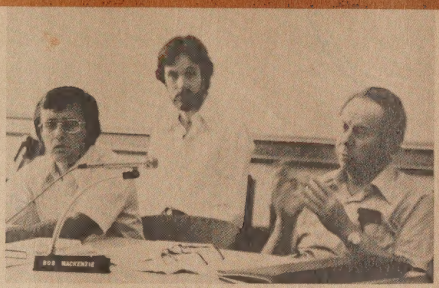
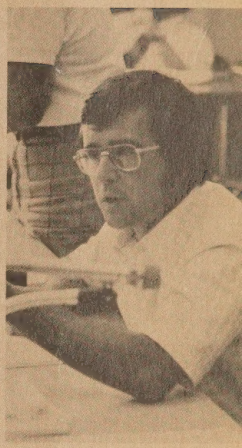
Brief To The Select Committee of the Ontario Legislature on Health Care Financing and Costs

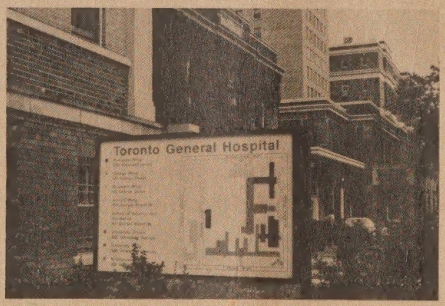
ONTARIO FEDERATION OF LABOUR

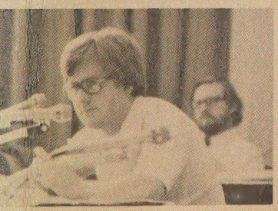
10

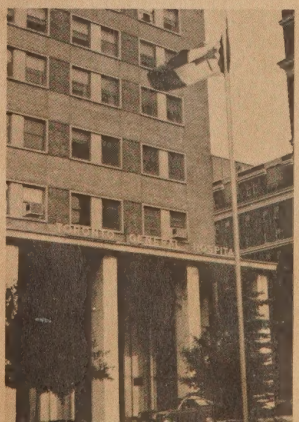
AUGUST 1978

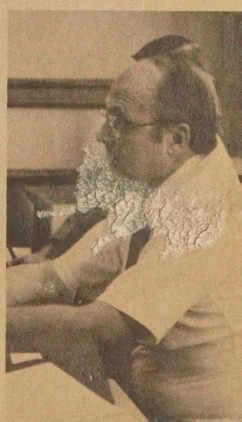












ONTARIO FEDERATION OF LABOUR

BRIEF

TO THE

SELECT COMMITTEE OF THE ONTARIO

LEGISLATURE ON HEALTH CARE

FINANCING AND COSTS

AUGUST 1978

Mister Chairman, committee members:

The trade union movement has played a significant role in the development of public health care in Canada. We know all too well the benefits that socialized medicine has brought the average man and woman. We are firmly committed to public health care and have a continued vested interest in its improvement and efficiency.

The Ontario Federation of Labour, representing 800,000 organized workers in this province, accordingly welcomes the opportunity to place its views before this committee.

WHERE ARE WE NOW?

Much has been made of the alleged fact that health care costs are escalating in an unmanageable manner. Opponents of public health care like to remark that OHIP expenditures have increased 152 percent since the Plan's inception - from $1.2 billion in 1970-71 to the current figure of $3.1 billion.

This fact, taken out of context and viewed without comparison to other economic indicators of the past eight years, indeed seems most alarming. However, using

1970 as the base year, Ministry of Health spending has increased at a slower rate than both the Gross Provincial Product and overall Ontario government expenditures. In the same period, per capita income has doubled in Ontario.

Ministry of Health spending as a percentage of Gross Provincial Product now stands at 4.2 percent - the second lowest figure since OHIP was inaugurated. Ministerial spending in 1978-79 as a percentage of overall government expenditure is estimated to remain at this year's level of 28.2 percent. This is appreciably lower than the 1972-73 level of 30.23 percent.

Certainly, the above figures should not give rise to complacency. At the same time, however, we must resist simplistic analyses of dollar costs of health care delivery in this province.

One should not forget the effects a consumer price index rise of nearly 70 percent over the past eight years has had on health care costs. Nor should we forget that a population rise of more than 12 percent over the same period contributed to increased demand for medical services.

When all is said and done, the uncontestable fact remains that public health care costs in Ontario have risen in line with overall growth in the provincial economy. That does not mean, as you will see below, that we feel the present OHIP system is without room for very major improvement. It does mean, however, that we will not tolerate attempts to make health care the whipping boy for perceived public objection to government spending.

In that regard, we were pleased to see that information supplied to this committee by the Ministry of Treasury, Economics and Intergovernmental Affairs (TEIGA) noted that public health insurance is superior to anything available in the private sector. Indeed the most convincing proof of this lies to the south. The United States, with no universal public health insurance scheme, spent 8.3 percent of GNP on personal health care in 1975. In that same year Canada spent 5.6 percent and Ontario 5.1 percent.

A healthy population means an energetic and productive Ontario. It means government savings to provide tax relief for the low and middle income earner. It means funds freed for uses in other areas such as job creation and social services. Above all, it means we have shown

ourselves to be a civilized society, one whose people are willing to share their good fortune with the less fortunate.

To reach this goal, however, much that is current practice in the present system must be stopped. And much that can be done to BOTH lower costs and improve the delivery of health care must be adopted.

We now have what by nearly everyone's estimation is an over-centralized and inefficient health care delivery system. Despite the notion that centralization reduces costs and inefficiency, the OHIP experience has left us with a system that is too often both impersonal and ineffective. At the the base of this problem is the fact that we have developed a capital - rather than labour - intensive health care system.

Ontario public hospital insurance was inaugurated in 1959. The political decision to wait twelve years before introducing health insurance conditioned much of a cost-conscious populace to use hospitals (where health care was directly subsidized) over private physicians. Overcrowded emergency wards and a rate of minor surgery three times that of England are but two costly maninfestations of our institution-centred system.

While no one would deny that medical advances are also contributing to rising health costs, we (in typically North American fashion) are over-awed and over-reliant upon technology. Technology can mean efficiency and savings. However, if we were to change the focus of our system to preventive rather than curative medicine, there would be a diminished need for great numbers of machines to treat diseases and illnesses that might have been arrested at an early stage. Capital saved might thus be channeled into more socially and fiscally profitable health areas.

Our free enterprise market economy plays a major role in this area, with both medical equipment and pharmaceutical companies producing ever more complex and ever more questionable products, sold to health care professionals who are easily convinced of the worth of such items. Pharmaceutical firms in 1977 spent the equivalent of $1,000 for each Canadian doctor on advertising their packaging of generic drugs.

There is almost no emphasis on preventive medicine within our present system. Of every Ministry of Health dollar, only three cents is spent on preventive measures! Small wonder, then, that our health costs are so high. The focus is on sickness, rather than health.

More disturbing is the fact that we seem to be placing even less emphasis on preventive medicine today than yesterday. For example, as levels of public immunization are falling off, we have seen several minor recurrences of diseases we thought had been eliminated. Unless we are vigilant in this area, we may again find our health costs needlessly inflated in a fight against contagions we thought were a thing of the past.

As convinced believers in the benefits of public enterprise, we are frustrated at the obvious inefficiency and lack of co-ordination exhibited by OHIP. There is something terribly wrong when an organization cannot account for the fact that it has more than half again as many participants registered than people living in our province.

With the exception of Saskatchewan, public health care was reluctantly established by governments fundamentally opposed on ideological grounds to socialized medicine. This is clearly revealed in Ontario, both in the degree of privatization of services (laboratories, nursing homes, drugs, etc.) and the system's apparent inability to police itself.

OHIP does little to protect itself from physician overbilling or the provision of unnecessary services. It has been unable, as anyone reading a paper over the past several years knows, to control expenses through private laboratories. It lacks the necessary legislative authority to move in such critical areas as occupational health and safety.

Increased privatization has meant increased costs as profit and not service becomes the byword.

There seems to be little evident planning to meet predictable future needs. By the year 2000, experts tell us nearly 12 percent of this province's population will be over 65 years of age. It is estimated that nearly half of all acute hospital patient days will be taken up by this group. These facts present us with a major health care challenge that should be appreciated and acted upon today.

Labour costs have certainly been a major factor in rising health care expenditures. However, these costs have reflected a catching up to a decent standard of living by occupational groups who were - by anyone's estimation - grossly underpaid. These men and women should not be expected to suffer when OHIP permits such absurd

practices as allowing salaried medical staff in hospital academic and teaching positions to bill the Plan on a fee-for-service basis. Nor do we accept that health care costs be realized through wholesale staff cutbacks. We all know that cutbacks have occurred in our hospitals, and we are concerned that this might be placing us perilously close to a crisis situation.

Most discouraging to all who support public health care has been OHIP's inability to reach many disadvantaged groups in our society. Many of our poor, our native peoples, our immigrants and our aged have been largely untouched by the present system.

This is in large part due to a lack of systematic information as to what services are available, who makes them available and where they are available. If as much money were spent on an OHIP information campaign as has been spent on the government's successful seatbelt campaign, we would both improve the delivery of services and effect savings. For these disadvantaged people inevitably become charges on the system after preventable and detectable illness have reached an advanced or critical state.

The present government also refused to integrate such ancillary health care needs as glasses, prescription drugs, dental service, prosthetic devices and hearing aids into OHIP. The inability of many of our fellow citizens to afford such necessities is both contrary to the spirit of public health care and dangerous to the health habits of the general populace.

An overwhelming number of physicians in this province are drawn from urban, middle-class backgrounds, and naturally enough wish to practice in such an environment. The result is that many people find their doctor incapable of understanding their particular geographic, cultural or linguistic background. It costs over $100,000 to train a physician in this province. These people are entitled to a return on their investment too, and our medical schools should endeavour to recruit students from a demographic cross-section of Ontario.

As we mentioned above, our concern is to bring about greater efficiency and a lowering of costs to a system that has the inherent ability to ensure both.

WHERE SHOULD WE GO?

If the question is how to effect cost reduction and streamline OHIP, the answer is firstly to integrate services to avoid duplication and, secondly, partially decentralize to put an end to unwieldy bureaucracy and needless capital expenditure.

To be effective from both a utilization and cost/benefit basis, health care must be brought into the community at large. We believe the best vehicle to effect this is the concept of the community clinic placing health and social services offered by basic teams of medical, dental and social service workers under one roof. With the emphasis on preventive medicine, it would also provide laboratory, X-Ray and pharmaceutical services on an out-patient basis. A number of specialists' services would be available, depending on the nature of the community (i.e. a resource community such as Sudbury would require an occupational health specialist on full-time staff).

Equally important, the opportunity would exist to involve more of the community in the information of health care requirements for their area. We believe a community's residents should have some input into programming and budget allocation - a reasonable function based on

the truism that people know better than any government what are the needs of their community.

This does not, however, mean a surrender of the Ministry's important role in setting standards and allocating funding.

Unlike existing hospital boards, which are elitist and unrepresentative, the government should insure any consultative community body reflect the demographic cross-section of the area it served. And, unlike the District Health Councils recently established by the Ministry of Health, it must be more than an advisory body adding weight to an already top-heavy bureaucracy. The Ministry should come to the community, not vice-versa.

We also believe that much health work, especially at the preventive level, is routine, and might be allocated to increased numbers of nurse-practitioners and paramedics.

Home care is another avenue of efficient and less costly health care. We in Canada tend to institutionalize individuals as soon as they lose their full ability to function in the community. Studies carried out in this

country and the actual experience of home care programs in such nations as the United Kingdom prove that home care is both more humane and less expensive than institutional care. In addition, it relieves pressure on hospital and nursing home beds, adds to the psychological well-being of patients (so important to speedy recovery) and makes more effective use of nursing talent. Again, the local clinic provides a complementary base for such activity.

The government must use its fiscal power to ensure that the attitudes of future generations of health care specialists are different from the prevailing disposition. Medical schools must begin to educate all young physicians in the art of preventive medicine. Those medical schools which have been enlightened enough to establish community medicine programs should be rewarded with a shift in educational funding in their direction.

As mentioned above, more research must be conducted into present and anticipated trends in health care.

Increased attention and funding must be devoted to nutrition and fitness instruction, in both the school and the work place. Investment in a healthier populace means long-term savings.

Similarly, let us not forget that decent housing, an adequate standard of living and a clean environment are all necessary if we are serious about lowering health costs. Governments possess the power to ensure this occurs.

HOW DO WE GET THERE?

Obviously, the above suggestions will cost money. Considerable amounts of it. Yet, the alternative of letting the system continue makes the mid and long term savings to be made from action along the lines, we have suggested most attractive.

We are not so irresponsible as to appear before you without suggesting ways an improved public health care system might be financed.

This province has operated a direct charge system for public health care since hospital insurance was introduced nearly two decades ago. We think it is time this peculiar philosophy of public health care was abandoned.

OHIP Premiums are a regressive, unjust and inefficient way of funding public health care. TEIGA maintains that premiums can be afforded by everyone, despite the

fact that all families with more than $5,000 in taxable income pay the same annual premium of $456. For all too many Ontario families, $456 is the difference between an adequate and substandard lifestyle.

In addition, over 13 percent of certificate holders still pay full premium costs without employer or government subsidization. As trade unionists, we are well aware that very large numbers of these men and women are unorganized workers who most need premium relief and suffer from a lack of it.

Premiums are no deterrent, nor (as TEIGA would have us believe) do they remind the public that health care is not "free". They are not a user charge, and do not rise with increased usage. Rather, they are an inducement to overuse the system by encouraging people to "get their money's worth". The "visibility" argument is at best a moot point.

OHIP Premiums are regressive to the point that two individuals earning the same income pay different rates depending on the extent of employer subsidization.

TEIGA says that the question of premium is not a key issue. Well, we want to let them know through you that it is THE issue to us - a matter of equity and progressivity in taxation and government service.

The Ontario Federation of Labour bitterly condemned the recommendations of the Taylor report released last January. We rejected them then, and we reject them now, as discriminatory, regressive and mean-spirited.

The indexing of premiums is nothing more than an indexation of inequity, and as such is unacceptable.

We utterly reject the idea of deterrent fees.

A levy on first day hospital visits is simply a tax on the sick and represents the complete antithesis of the philosophy underlying public health care. Such suggestions do not reduce health care costs, they simply redistribute them.

We were alarmed to read suggestions that OHIP subscribers over the age of 65 to pay premiums. Not only is such an idea morally reprehensible, but it would add yet another regressive tax to our seniors' already inadequate income. Treasury officials also estimate that only one-fifth of our 800,000 pensioners can afford premiums, and that the cost of finding these men and women would be prohibitive.

We realize that some organizations may well recommend a continuation of status quo funding in view of the fact that the employer currently assumes full premium payment. However, we suggest that their apprehensions of economic loss are misplaced. Adoption of health care financing as we are suggesting below will result, on a taxation basis, in a net saving for nearly all Ontario workers. Secondly, as most contracts run no longer than two years, employees will be able to negotiate for any short-term physical loss on their pay cheque.

Certainly, most trade unions care about those who are not organized, and who cannot bargain collectively for employer-paid OHIP. Abolition of premiums will provide appreciable financial relief for this large group of taxpayers.

It is estimated that $975 million will be raised in premiums in 1978-79. If we are to do away with premium payment as a means of financing public health care, we are faced with only two possible alternatives - a payroll tax or total funding from general revenue.

Basically, we see little difference between an employer payroll tax system and the present scheme whereby

corporations pay a share of the premium burden. In fact, it has one large glaring defect. An employer payroll tax would adversely affect labour-intensive industry at a time when job creation should be the number one priority of this and every other government. In addition, such a tax would only be shifted backward to wages or forward to prices, hurting working people in the final analysis. It also produces more red tape for small business when other government departments are moving to reduce the paper burden on this economic group.

We cannot see any advantage of an employee payroll tax. By itself, it would do nothing to increase corporate responsibility for health care costs. Were a ceiling applied, it would become regressive. A payroll tax is unfair in that it taxes only wage and salary income. Those earning other forms of income escape. It also further complicates the collective bargaining process, with some unions being able to negotiate for employer-paid taxes, others for partial payment, and others for nothing at all. The net result is again one of unbalance and inequity.

The funding of public health care from general revenue is the most acceptable alternative to the status quo. Six out of ten provinces now follow this

practice. We do not feel that the tax system would be unduly complicated by such a system. Indeed, major savings could be realized from the dismantling of the premium collection bureaucracy, and its employees more productively used elsewhere.

We appreciate that funding OHIP from general revenue will necessitate some increase in both the personal and corporate income tax rates. However, we feel this can be undertaken without the difficulties proponents of the status quo have suggested.

A revamping of health care funding must in our view be linked to the positive reforms mentioned above. These changes, as we have pointed out, are designed to reduce costs over the medium and long term.

The federal government continues to provide a large portion of current OHIP costs. While TEIGA has maintained that the winding down of direct federal government health transfer payments has left the province to bear 70 percent of OHIP costs, the substitution of other tax sharing arrangements have, for the time being at least, actually increased the federal contribution to nearly one half of health care expenditures. Accordingly, Ontario has more

flexibility in how it arranges its share of funding than we are being led to believe.

Individuals now assume 52 percent of OHIP costs - $300 million in direct premium payments and $200 million in income tax support. Yet, the regressive feature of premium payment means that low and middle income taxpayers are called upon to contribute more than their fair share of health care costs.

Under a scheme of funding from general revenue, middle and lower income taxpayers would pay less than they now do in premium payment and "hidden" taxation.

Adding injustice to the present funding arrangement is the fact that those with higher incomes receive a greater return on their proportionately smaller health care investment. A recent study by the Ontario Economic Council shows that families in the $20,000 income bracket receive an average of $253 in medical care benefits from the system, while families with incomes of $7,000 receive only $145.

Abolishing premiums and funding health care from general revenue taxes those best able to pay.

Nor do we believe that upper-middle and upper income Ontarians are so highly taxed that it would be unreasonable to ask they bear any short-term increase in the interest of long-term health care efficiency. You are, we are sure, aware of the provincial Treasury report that showed that Ontario citizens pay less taxes than do taxpayers residing in Buffalo, Cleveland and Detroit. While our personal income taxes are higher than those in neighbouring states, lower property taxes and greater governmental and social services more than compensate for this.

At 44 percent, Ontario personal income tax, (p.i.t.), is the second lowest in the nation. While we believe that some upward revision of this rate would be necessary under a general revenue funded health care system, bringing our p.i.t. rate to even the national average of just under 51 percent would generate an additional $500 million. This would mean an additional tax increase of approximately $150 for the taxpayer earning the average industrial wage in Ontario - hardly an onerous burden, and indeed a net saving when one considers current premium costs and the return in better health service.

Having said this, however, we must emphatically add our belief that any personal income tax increase could be brought down well below this hypothetical 51 percent

level if the corporate sector was to assume a share of health care costs that realistically reflected both its capital wealth and well-documented contributions to the deterioration of the personal health of Ontario citizens.

Corporations can well afford to contribute a greater amount to this province's health care system. The government likes to perpetuate the fiscal charade that employers pay 70 percent of premium costs. In fact, employer-paid premiums are deductible tax credits for employers but for employees taxable benefits. While employer OHIP payments will amount to $675 million in 1978-79, $250 million is reclaimed in tax write-offs. Individuals actually assume more than half of premium costs, through either a direct regressive tax or through a disproportionate share of progressive income tax. Employees also negotiate such fringe benefits as OHIP in exchange for direct wage advancement, and are further disadvantaged under the status quo.

We in the labour movement are all too aware of the damage done to our health and environment by corporate avarice and pollution. Our on-going campaign for adequate occupational health and safety legislation reflects our concerns with this cost to individual health and productivity and general prosperity. The corporate sector benefits greatly from a healthy work force (i.e. lower

absenteeism, greater productivity, etc.). We think it more than fair that it assume a greater share of health care responsibility than it currently does.

Shifting the employer share of health care costs to corporate tax is also more progressive in that profitable firms pay more than weaker companies. Nor do labour-intensive industries bear an unfair share of the burden, as is the case now.

We do not accept the contention that increased corporate tax rates will lead to problems with Ontario's industrial competitiveness. The government uses this argument for failure to act to lower our regressive sales tax, clean up the environment or raise the minimum wage to a decent level.

The problems of Ontario industrial competitiveness lie in areas other than taxation, and the average man and woman should no longer be penalized for this economic fact of life.

Before concluding, we should mention our dissatisfaction with the current fee-for-service physician payment - a system that encourages assembly-line health care. We would hope this committee might make some suggestions as to alternate forms of doctor reimbursement.

CONCLUSION

Mr. Chairman, we believe Ontarians can be proud of their public health system. All the more so when we see that, even with the system's faults, this province and this country spend less of their G.N.P. on health care than does the United States with its largely private scheme. Indeed, OHIP is but a part of the Canadian tradition of public enterprise that culturally sets us aside from our American neighbours.

We are pleased that no group has dared to suggest the dismantling of this systen or its further privatization. As pioneer advocates of socialized medicine, we are all too aware of the inequities and drawbacks of the current system. We believe that prompt attention to the recommendations made in this brief will go a long way to providing more effective, more efficient and less costly health care for the people of Ontario.

All of which is respectfully submitted:

Clifford Pilkey,
President.

Terry Meagher,
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Press Release

Ontario Federation of Labour

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FOR IMMEDIATE RELEASE

August 29, 1978

LABOUR WANTS MAJOR CHANGES IN OHIP STRUCTURE AND FINANCING

TORONTO - More efficient, effective and less costly health care could be realized in a decentralized, community-oriented OHIP plan funded from general tax revenue.

An August 29 OFL brief to the Select Committee of the Ontario Legislature on Health Care Financing and Costs defends public health care as more cost-effective than that provided by the private sector in such jurisdictions as the United States. It also notes that, contrary to public perception, health care spending has increased at a slower rate than per capita income, gross provincial product and overall provincial government expenditures.

The brief, presented by Federation president Cliff Pilkey, points out only three cents of every health care dollar is spent on preventive medicine. It contends much money that has gone for facilities and equipment to treat illnesses that might have been cured at an earlier stage could have been saved with a greater commitment to preventive medicine.

A decentralization of medical services through community clinics administered by representative local boards is suggested as another means to reduce administrative and capital costs.

The financing of OHIP through premiums is condemned as regressive, unjust and inefficient. After rejecting either employer or employee payroll taxes, the brief recommends total funding of health care from personal and corporate income tax. It notes an estimated resultant tax increase of $150 for a taxpayer earning the average industrial wage would be less than current premium payments.

- 30 -

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Press Release